Application Form for Registration of Clinical Establishments

I. ESTABLISHMENT DETAILS

1. Name of the establishment: ____________________________________________________________

2. Address:
   Village/Town: _____________________________ Block: _____________________________
   District: __________________ State: ___________ Pin code:___________________________
   Tel No (with STD code): _______________ Mobile: ______________ Fax: _______________
   Email ID: _____________________________ Website (if any): __________________________

3. Month and Year of starting: ________________________________

(From 4 to 11 mark all whichever are applicable)

4. Location:
   Rural
   Urban
   Metro
   Notified / inaccessible areas (including Hilly / tribal areas)

5. Ownership of Services

   Government/Public Sector
   Central government ☐ State government ☐ Local government (Municipality, Zilla parishad, etc)
   Public Sector Undertaking ☐ Other ministries and departments (Railways, Police, etc.)
   Employee State Insurance Corporation ☐ Autonomous organization under Government ☐

   Non-Government / Private Sector
   Individual Proprietorship ☐ Partnership ☐ Registered companies (registered under
central/provincial/state Act) ☐ Society/trust (Registered under central/provincial/state Act) ☐

6. Name of the owner of Clinical Establishment: ____________________________________________
   Address:
   Village/Town: _____________________________ Block: _____________________________
   District: __________________ State: ___________ Pin code:___________________________
   Tel No (with STD code): _______________ Mobile: ______________ Fax: _______________
   Email ID: _____________________________

7. Name, Designation and Qualification of person in-charge of the clinical establishment: ______
   Qualification(s): __________________________________________
   Registration Number: ________________________________
   Name of Central/State Council (with which registered): __________________
   Tel No (with STD code): _______ Fax: _______ Mobile: _______ E-mail ID: ________________

8. Systems of Medicine offered: (please tick whichever is applicable)
   ☐ Allopathy ☐ Ayurveda ☐ Unani ☐ Siddha ☐ Homoeopathy ☐ Yoga ☐ Naturopathy ☐ Sowa-Rigpa
   ☐

9. Type of establishment : (please tick whichever is applicable)
   ☐ (I). Clinic (Outpatient)
   ☐
   • Single practitioner
     (Consultation services only/with diagnostic services/with short stay facility)
- Poly clinic
  (Consultation services only/with diagnostic services/with short stay facility)
- Dispensary
- Health Checkup Centre

(II). Day Care facility
Medical       Surgical       Medical SPA       Wellness centers (where qualified medical professionals are available to supervise the services).

(III). Hospitals including Nursing Home (outpatient and inpatient):
- Hospital Level 1 a
- Hospital Level 1 b
- Hospital Level 2
- Hospital Level 3 (Non teaching)
- Hospital Level 4 (Teaching)

(IV). Dental Clinics and Dental Hospital:

a. Dental clinics
   i. Single practitioner
   ii. Poly Clinics (dental)

b. Dental Hospitals (specialties as listed in the IDC Act.)
   i. Oral and maxillofacial surgery
   ii. Oral medicine and radiology
   iii. Orthodontics
   iv. Conservative dentistry and Endodontics
   v. Periodontics
   vi. Pedodontics and preventive dentistry
   vii. Oral pathology and Microbiology
   viii. Prosthodontics and crown bridge
   ix. Public health dentistry

(V). Diagnostic Centre

A. Medical Diagnostic Laboratories:
   - Pathology
   - Biochemistry
   - Microbiology
   - Molecular Biology and Genetic Labs
   - Virology

B. Diagnostic Imaging centers

i. Radiology
   - General radiology
   - Interventional radiology

ii. Electromagnetic imaging
   - Magnetic Resonance Imaging (MRI),
   - Positron Emission Tomography (PET) Scan

iii. Ultrasound

C. Miscellaneous
Electro Cardiography (ECG)  Echocardiography
Tread Mill Test  Electro Myography (EMG)
Electro Encephalography (EEG)  Electrophysiological studies
Mammography

D. Collection centers
For the clinical labs and diagnostic centres shall function under registered clinical establishment
Yes/No
if Yes, then No of Collection Centre: __________

(VI). Allied Health professions:
- Audiology
- Behavioral health (counseling, marriage and family therapy etc)
- Exercise physiology
- Nuclear medicine technology
- Medical Laboratory Scientist
- Dietetics
- Occupational therapy
- Optometry
- Orthoptics
- Orthotics and prosthetics
- Osteopathy
- Paramedic
- Podiatry
- Health Psychology / Clinical Psychology
- Physiotherapy
- Radiation therapy
- Radiography / Medical imaging
- Respiratory Therapy
- Sonography
- Speech pathology

(VII) AYUSH

Ayurveda
Ausadh Chikitsa  Shalya Chikitsa  Shodhan Chikitsa  Rasayana
Pathya Vyavastha

Yoga
Ashtang  Yoga

Unani
Matab Jarahat  Ilaj-bit-Tadbeer  Hifzan-e-Sehat

Siddha
Maruthuvam  Sirappu Maruthuvam  Varmam Thokknam & Yoga

Homoeopathy
General Homoeopathy
II. TYPES OF SERVICE

- **TYPE**
  - General Practice Services
  - Single Specialty Services
  - Multi Specialty Services (including Palliative care Centre, Trauma Centre, Maternity Home - applicable for hospitals only)
  - Super Specialty Services

- **SPECIALITY SPECIFIC**

  Medical Specialties – for which candidates must possess recognized PG degree (MD/Diploma/DNB or its equivalent degree)

  i. Anesthesiology
  ii. Aviation Medicine
  iii. Community Medicine
  iv. Dermatology, Venerology and Leprosy
  v. Family Medicine
  vi. General Medicine
  vii. Geriatrics
  viii. ImmunoHaematology and Blood Transfusion
  ix. Nuclear Medicine
  x. Paediatrics
  xi. Physical Medicine Rehabilitation
  xii. Psychiatry
  xiii. Radio-diagnosis
  xiv. Radio-therapy
  xv. Rheumatology
  xvi. Sports Medicine
  xvii. Tropical Medicine
  xviii. Tuberculosis & Respiratory Medicine or Pulmonary Medicine

  **Surgical specialties** - for which candidates must possess, recognized PG degree (MS/Diploma/DNB or its equivalent degree)

  i. Otorhinolaryngology
  ii. General Surgery
  iii. Ophthalmology
  iv. Orthopedics
  v. Obstetrics & Gynecology

  **Medical Super specialties** –
  i. Cardiology
  ii. Clinical Hematology including Stem Cell Therapy
  iii. Clinical Pharmacology
iv. Endocrinology  
v. Immunology  
vi. Medical Gastroenterology  
vii. Medical Genetics  
viii. Medical Oncology  
ix. Neonatology  
x. Nephrology  
xi. Neurology  
xii. Neuro-radiology  

**Surgical Super-specialities-**  
i. Cardiovascular thoracic Surgery  
ii. Urology  
iii. Neuro-Surgery  
v. Plastic & Reconstructive Surgery  
vi. Surgical Gastroenterology  
vii. Surgical Oncology  
viii. Endocrine Surgery  
ix. Gynecological Oncology  
x. Vascular Surgery  

**III INFRASTRUCTURE DETAILS**  

10. **Area of the establishment** (in sqft):  
a) Total Area: ________________________  
b) Constructed area: ________________________  

11. **Out Patient Department:**  
11.1 Total no. of OPD Clinics: __________________________  

11.2 Specialty-wise distribution of OPD Clinic  

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<thead>
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<th>S.No.</th>
<th>Specialty</th>
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12. **In Patient Department:**  
12.1. Total number of beds: __________________________  
12.2. Specialty-wise distribution of beds, please specify:  

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<thead>
<tr>
<th>S.No.</th>
<th>Specialty</th>
<th>Beds</th>
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13. **Biomedical waste Management**  
13.1 **Method of treatment and/or disposal of Bio-medical waste**  
☐ Through Common Facility  ☐ Onsite Facility  
☐ Any other (please specify): ________
13.2. Whether authorization from Pollution Control Board/Pollution Control Committee obtained?

☐ Yes ☐ No ☐ Applied For ☐ Not Applicable

IV HUMAN RESOURCES

14. Total number of Staff (as on date of application):
No. of permanent staff: __________ No. of temporary staff: ________________

Please furnish the following details:-

<table>
<thead>
<tr>
<th>Category of staff</th>
<th>Name</th>
<th>Qualification</th>
<th>Registration No</th>
<th>Nature of service</th>
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</thead>
<tbody>
<tr>
<td>Doctors</td>
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<tr>
<td>Nursing staff</td>
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<tr>
<td>Para-medical staff</td>
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<tr>
<td>Pharmacists</td>
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<tr>
<td>Administrative staff</td>
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<tr>
<td>Others, please specify</td>
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Separate annexure may be attached.

Support Staff

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<tr>
<th>Category</th>
<th>Total no.</th>
<th>Remark</th>
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</table>

15. Payment options for Registration Fees:

☐ Online payment ☐ Demand Draft ☐ Bank Challan

☐ Amount (in Rs): ________________________________________________

Details: _______________________________________________________

Receipt No. ____________________________________________________

I, ________________________________ on behalf of myself and the company/society/association/body hereby declare that the statements above are correct and true to the best of my knowledge and I shall abide by all the provisions made under the Clinical Establishment (Registration and Regulation) Act 2010.

I undertake that I shall inform the DistrictRegistering Authority of any changes in the particulars given above.

I shall comply with the minimum standards prescribed under Clinical Establishment Act for the services provided by us and also all other conditions of registration as stipulated under the aforesaid Act and Rule there-under.

Place: ____________________________ Signature of the Authorized Signatory

Date: ______________________________ Office Seal